MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Friday, November 8, 2002
9:07 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Public Comment

MR. HACKBARTH: Now we'll have our public comment period.

MR. PYLES: Thanks very much. I'm Jim Pyles, representing the American Association for Home Care.

A couple of the points I wanted to mention, I think, have been touched on by Dr. Rowe and by Ms. Raphael and Senator Durenberger. But just let me summarize a couple of things that I think are very important to keep in mind with respect to home health.

One is this sector has experienced the most radical changes in payments, patients, and providers of any benefit category in the history of the Medicare program, I believe. I don't know of any other program that has seen over a shorter period of time the radical change, 52 percent reduction in payments between 1997 and 1999 but a 40 percent reduction in providers, and about a one-third reduction in patients treated.

We know that distribution was heavily concentrated in the most complex, costly patients. So the patient population has shifted rather radically.

Higher nursing costs, certainly every provider is experiencing those, but as Ms. Raphael says, the personnel costs for home health agencies are much higher than for any other providers. So the higher nursing costs hit home health agencies much harder.

Plus, it is not just the impact is greater but the kinds of nurses you need in home health are nurses with particular expertise to deal with things that nurses in facilities do not have to deal with. Retaining experienced nurses is extraordinarily difficult. You have to pay these people and provide appropriate incentives for them to stay in the business. It is a tough, tough job.

We also know that the service mix has shifted under PPS away from lower skilled people to higher skilled people, once again placing more pressure on higher cost employees. Medical liability costs have gone up for home health just as they have for every other provider. Health insurance costs have increased by double digit amounts in the last two years and are projected to go up 30 percent next year. The same is true for home health agencies.

The difference with home health agencies is most of their costs are in the personnel and fringe benefit areas, as Senator Durenberger pointed out.

HIPAA compliance, transaction, privacy costs, both of those standards go into effect next year. Home health is struggling hard to try to comply with those new standards.

Understand, too, and remember if you would, you recommended previously that what this industry needed most was stability. That is absolutely essential because with the dramatic decline in reimbursement under the government programs has left a residual impact. Many, many agencies now are still making repayments on extended repayment plans to CMS that were caused by dramatic and abrupt reductions under the interim payment system.

They could not go into the market and borrow money to pay that off, so they have had to just enter into those repayment plans with CMS. The percentage rate on those repayment plans is 14 percent. Fourteen percent in this market. That's because they cannot go out into the market and find other money to pay that off

Adding insult to injury, two very recent developments. One is the 15 percent cut has just begun to take effect. Of course we know it's about a 7 percent reduction, but that's on top of the 52 percent cuts we previously had. Agencies are scrambling right now to try to accommodate that and they're doing it, some of them we're finding now are doing it by just refusing to treat the more costly patients. They can't do it. They don't have the money to do it or the personnel to do

it.

And most recently, as recently as last week, the largest financing organization in the country for home health collapsed. National Century Financial Enterprises, it's been in the headlines of the business sections of the paper, has collapsed. They were in the business of financing receivables. This was the only financing source for many home health agencies.

Just this week CMS has told agencies that were relying on that financing that CMS will cut off all further payments to home health unless they can find an alternate source. There is no alternate source of funding for many of these agencies.

Over the next few weeks you're going to see some major reductions in providers, in home health providers in this country as a result of these events.

One last thing I would mention to you on the number of offices, that 7,000 agents HHA number may be deceptively high because within the last year CMS has issued a policy saying that states can require home health agencies to get a separate provider number in each state in which they do business. For example, in the DC Metropolitan area we have commonly the situation where one agency since maybe 1965 has served patients in DC, Maryland and Virginia. Under this recent policy now, that one agency will have to establish two additional provider numbers, giving the appearance of an increase in the number of providers. But what they're really doing is converting branch offices to freestanding providers.

This is going to skew that number higher. So I suspect you actually have an even greater net reduction in the number of providers.

One last thing I would mention is that the house passed bill, a Medicare bill, which would have eliminated the 15 percent cut, also included a provision recommending that you look at the budgetary impact of your recommendations when you make them in the future. Should you decide to follow that, I would urge you to also look at the fact that the provision in the House bill for home health relief is self-funded. It takes the cost of eliminating the 15 percent cut out of market basket updates in future years so that the net cost of eliminating the 15 percent cut is zero.

Thanks very much.

MR. MAY: Thank you. I'm Don May with the American Hospital Association and I appreciate the opportunity to comment here today.

We'd like to just make one point on your discussion on the transfer provision. As you might guess, the AHA is strongly opposed to any expansion of the transfer policy, but it's because it's a bad policy.

A prospective payment system is based on a system of averages and with any DRG we can have a low length of stay and be able to cover our costs for that, have a high length of stay and not cover costs. But at the end of the day, at the end of the year, you hope that the system of averages has worked in your favor.

Expanding the transfer provision and reducing payments to cases that get sent to post-acute care means that we're going to lose on those cases that have a lower length of stay and we lose on the cases that have a higher length of stay.

It's just a policy that doesn't make sense and has a huge impact on hospitals and the care and the funding that's available to provide access to care.

We have done research on this and all the research that we've been able to come up with show that patients -- and I think it's consistent across most research that's been done on this -- patients who receive post-acute care are sicker. They're getting post-acute care for a reason.

Whether that's that they live in a nursing home, they need extended care at home. But

regardless of whether they're leaving the hospital early because a hospital is able to do something in a more efficient manner, they're going to be sicker and they need that care. Penalizing a hospital is not the way about addressing the post-acute care issues.

One of the arguments for doing this is that there's a lack of equity in the system. That those hospitals who have access to post-acute care are able to use that service more often and have a lower length of stay than those other hospitals.

The policy to fix that solution is not to cut those hospitals who have access to post-acute care. It's about finding ways of putting post-acute care in those areas where there's not access. There are two very distinct and different policies there and we really need to focus on extending post-acute care in those areas that don't have it and not making cuts to hospitals.

I was really encouraged by a lot of the discussion here and some of the real concerns that several commissioners brought up. I would like to make a quick note in the inpatient proposed rule that came out, CMS actually came up with different numbers than what Craig had as far as the impact. What we're hearing is that it's $1 billion for 13 more DRGs, $.9 billion, and $1.9 billion for expanding it to all DRGs.

We did some research as well once this was proposed, as you might imagine. Our estimates and the estimates of some others we've talked to indicate that it may be even more. It's very difficult to do the data analysis because we don't have patient identifiers that allow us to do all the exact linking.

But if we did, our estimates would only go up. This is consistent with other researchers.

What this means is remember it's not just a one year hit. $1 billion or $1.9 billion in one year means $10 billion in five years and $20 billion in 10 years. The impact of that is tremendous on America's hospitals. And it's something that, as you move forward, we would strongly recommend that you be cautious in recommending anything on this.

I was real encouraged by some of the other ideas they came out. In looking at some of the three primary DRGs that seem to be problematic, being real cautious and looking at swing beds and the impact on rural hospitals, and looking at the whole bundle and whether there are other ways of looking at this that could address some of the concerns that the Commission has raised, that Congress has raised without just slashing payments in a way that doesn't improve access to post-acute care and doesn't address the fundamental problems that hospitals have today that all providers are having today with workforce shortages.

This is really not the time to be cutting payments when workforce shortages are driving up costs. Liability and professional liability costs are going up. All the trends indicate that the costs of providers are going up. This is an opposite direction if you want to continue to ensure access to both hospital and post-acute care.

Thank you.

MR. LISK: I just wanted to say that in the paper I had indicated -- and I didn't give the CMS numbers because the CMS numbers that were in the proposed rule were wrong. They don't have official revised numbers. We will provide you numbers in terms of our estimate of what the impact is at the December meeting. But the numbers that CMS provided, first of all, that were in the proposed rule, that were just cited, also included the current 10 DRGs but, in fact, the numbers are not actually correct and have been revised downward. But I can't say what those numbers are at this point in time.

MS. THOMPSON: Hi. Thank you for the opportunity to comment. I'm Cathy Thompson with the Visiting Nurse Association of America.

VNAA is just starting now to look at data on how the nursing shortage is affecting visiting nurse agencies in particular. We don't have really good hard data at this time but we do want to work with MedPAC on getting that data.

We do show that there is about a 15 to 20 percent RN vacancy rate among visiting nurse associations and about a 25 to 30 percent home health aide vacancy rate. We do have data showing that those recruitment costs do eat significantly into the revenue of visiting nurse agencies.

My concern is that when data comes out, if data comes out showing that Medicare revenue exceeds expenditures that there will be a knee jerk reaction to then recommend or for Congress to consider decreases in Medicare reimbursement for home health or to not repeal the 15 percent cut which we know is pending in Congress.

Our data does show that if there are any margins at all, very small, they're completely wiped away by the technology cost to comply with that Medicare regulations, particularly OASIS and HIPAA and PPS. That VNAs budgets, on average, are quite small compared to the rest of the health care industry. And that they do disproportionately wipe out a lot of the revenue that VNAs have.

So in addition to the IT cost, the increased salaries and benefits to recruit nurses, during the shortage, and home health aides, in addition to losses in Medicare and managed care, we do have data on all of that and would love to share it with MedPAC, just to balance out when Medicare data under PPS becomes available.

We don't know what that's going to show now, but I just wanted to raise those issues. Thank you.

MR. HACKBARTH: Okay, thank you all.

[Whereupon, at 11:55 a.m., the meeting was adjourned.]